# IN-HOME SUPPORTIVE SERVICES PROGRAM COUNTY OF
# NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY

**(ADDRESSEE)**

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

The person you have chosen to provide services for you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. Here's why:

He/she did not complete one or more of the required steps of the provider enrollment process shown below.

- He/she did not complete, sign and return the IHSS Provider enrollment Form (SOC 426) to the county; and/or
- He/she did not attend an IHSS Provider Orientation; and/or
- He/she did not sign an IHSS Provider Enrollment Agreement (SOC 846); and/or
- Either he/she did not go through a criminal background check, or he/she did go through a criminal background check but he/she was found ineligible based on a conviction for a crime.

You must choose a different person to provide services. If you choose to continue receiving services from this provider, you will be responsible for paying him/her with your own money for any services provided.

If you need help finding a different provider, call _____ .